Office of the
Medicaid Inspector
General

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

Audit of Claims for Personal Care Services

Final Audit Report
Audit #: 21-5901

South Shore Home Health Services

Provider ID #: 01085496

NEW YORK STATE | Office of the Medicaid Inspector General

KATHY HOCHUL
Governor

FRANK T. WALSH, JR.
Acting Medicaid Inspector General

January 23, 2023

Ms. Jayne Rizzo, Operations Manager
South Shore Home Health Services
1225 Montauk Highway #2
Oakdale, NY 11769-1434

RE: Final Audit Report
Audit #: 21-5901
Provider #: 01085496

Dear Ms. Rizzo:

This is the Office of the Medicaid Inspector General's (OMIG) Final Audit Report for South Shore Home Health Services (Provider).

In accordance with Sections 30, 31 and 32 of the New York State Public Health Law, and Title 18 of the Official Compilation of the Codes, Rules and Regulations of the State of New York (NYCRR) Parts 504 and 517, OMIG performed an audit of Personal Care claims paid to the Provider from January 1, 2017 through December 31, 2019. The audit universe consisted of 28,710 claims totaling $4,989,750.03. The audit consisted of a random sample of 100 claims with Medicaid payments totaling $16,377.65 (Attachment A).

The Provider did not respond to OMIG's December 6, 2022 Draft Audit Report. OMIG has attached the sample detail for the paid claims determined to be in error. The adjusted point estimate overpaid is $214,830. The adjusted lower confidence limit of the amount overpaid is $30,615. We are 95% certain that the actual amount of the overpayment is greater than the lower confidence limit. This audit may be settled through repayment of the adjusted lower confidence limit of $30,615.

Your cooperation in this matter will be greatly appreciated. If you have any questions, please contact Shannon Kavanaugh-Gonzalez at (716) 847-3120 or through email at Shannon.Kavanaugh-Gonzalez@omig.ny.gov and refer to audit number 21-5901 in all correspondence.

Sincerely,

Vicki Meyer

Vicki Meyer, Audit Manager
Division of Medicaid Audit
Office of the Medicaid Inspector General

VM:pam
Attachments
Certified Mail Number: 7019 1120 0002 0847 7625
Return Receipt Requested
cc: Jackie Datkum, Area Agency Director

Table of Contents

Background, Objective, and Audit Scope

Background

The New York State Department of Health (DOH) is the single state agency responsible for the administration of the Medicaid program. As part of its responsibility as an independent entity within DOH, the Office of the Medicaid Inspector General (OMIG) conducts audits and reviews of various providers of Medicaid reimbursable services, equipment and supplies. These audits and reviews are directed at assessing provider compliance with applicable laws, regulations, rules and policies of the Medicaid program as set forth in New York Public Health Law, New York Social Services Law, the regulations of DOH (Titles 10 and 18 of the New York Codes Rules and Regulations), the regulations of the Office of Mental Hygiene (Title 14 of the New York Codes Rules and Regulations), the regulations of the Education Department (Title 8 of the New York Codes Rules and Regulations), DOH's Medicaid Provider Manuals and *Medicaid Update* publications.

Reimbursement under the Medicaid Program is available for personal care services in accordance with provisions of Article 36 of the Public Health Law. Personal care services must be provided by an agency that is licensed or certified to operate as a home care agency by the New York State DOH; and that has a contract with the local social services district in which the agency is licensed or certified to provide services.

Title 18 NYCRR Section 505.14, defines personal care services as some or total assistance with personal hygiene, dressing and feeding, nutritional and environmental support functions and health-related tasks. Such services must be essential to the maintenance of the recipient's health and safety within his or her own home, as determined by the social services district in accordance with the regulations of DOH; ordered by the attending physician; based on an assessment of the recipient's needs; provided by a qualified person in accordance with a plan of care; and supervised by a registered professional nurse. The specific standards and criteria for personal care services are outlined in Title 10 NYCRR Part 766 and Title 18 NYCRR Section 505.14. The MMIS Provider Manual for Personal Care Services also provides program guidance for claiming Medicaid reimbursement for personal care services.

Objective

The objective of this audit was to assess South Shore Home Health Service's (Provider) adherence to applicable laws, regulations, rules and policies governing the New York State Medicaid program and to verify that:

- Medicaid reimbursable services were rendered for the dates billed;
- appropriate rate codes were billed for services rendered;
- patient related records contained the documentation required by the regulations; and,
- claims for payment were submitted in accordance with applicable rules and requirements.

Audit Scope

A review of Personal Care Service claims paid to the Provider by Medicaid for payment dates included in the period beginning January 1, 2017 and ending December 31, 2019, was completed.

The audit universe consisted of 28,710 claims totaling $4,989,750.03. The audit sample consisted of 100 claims totaling $16,377.65 (Attachment A).

Regulations of General Application

Each audit finding is supported by relevant regulations, policy statements and manuals. In addition, the audit findings in this audit are supported by regulations of general application to the Medicaid program. These regulations are provided below.

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment . . . and to keep for a period of six years from the date the care, services or supplies were furnished, all records necessary to disclose the nature and extent of services furnished and all information regarding claims for payment submitted by, or on behalf of, the provider . . . (e) to submit claims for payment only for services actually furnished and which were medically necessary or otherwise authorized under the Social Services Law when furnished and which were provided to eligible persons; (f) to submit claims on officially authorized claim forms in the manner specified by the department in conformance with the standards and procedures for claims submission; . . . (h) that the information provided in relation to any claim for payment shall be true, accurate and complete; and (i) to comply with the rules, regulations and official directives of the department." *18 NYCRR Section 504.3*

"Fee-for-service providers. (1) All providers . . . must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program. All records necessary to disclose the nature and extent of services furnished and the medical necessity therefor . . . must be kept by the provider for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later. (2) All information regarding claims for payment submitted by or on behalf of the provider is subject to audit for a period of six years from the date the care, services or supplies were furnished or billed, whichever is later, and must be furnished, upon request, to the department . . . for audit and review." *18 NYCRR Section 517.3(b)*

"An overpayment includes any amount not authorized to be paid under the medical assistance program, whether paid as the result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse or mistake." *18 NYCRR Section 518.1(c)*

"The department may require repayment from the person submitting an incorrect or improper claim, or the person causing such claim to be submitted, or the person receiving payment for the claim." *18 NYCRR Section 518.3(a)*

"The department may require repayment for inappropriate, improper, unnecessary or excessive care, services or supplies from the person furnishing them, or the person under whose supervision they were furnished, or the person causing them to be furnished. . . . Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record." *18 NYCRR Section 518.3(b)*

"Vendor payments for medical care and other items of medical assistance shall not be made unless such care or other items of assistance have been furnished on the basis of the appropriate authorization prescribed by the rules of the board and regulations of the department." *18 NYCRR Section 540.1*

"All bills for medical care, services and supplies shall contain: (1) patient name, case number and date of service; (2) itemization of the volume and specific types of care, services and supplies provided (including for a physician, his final diagnosis, and for drugs, the prescription filled); (3) the unit price and total cost of the care, services and supplies provided; . . . (8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished; that the amounts listed are due and owing . . . that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years from the date of payment . . . and that the provider understands that payment and satisfaction of this claim will be from Federal, State and local public funds and that he or she may be prosecuted under applicable Federal and State laws for any false claims, statements or documents, or concealment of a material fact provided . . ." *18 NYCRR Section 540.7(a)(1)-(3) and (8)*

"Medical care, services or supplies ordered or prescribed will be considered excessive or not medically necessary unless the medical basis and specific need for them are fully and properly documented in the client's medical record."

Audit Findings

OMIG issued a Draft Audit Report to the Provider on December 6, 2022. The Provider's response (Attachment D) to the December 6, 2022 Draft Audit Report stated that the Provider is in agreement with the Draft Audit Report findings. As a result, the total sample overpayment of $1,493.70 remains unchanged from the sample overpayment cited in the Draft Audit Report. A description of each finding, regulations, and the list of samples supporting each finding, appear below. Each sample may contain more than one error, and may be listed in more than one category of finding. A sample may only be disallowed once in an audit, however, each sample is subject to disallowance based on a single error.

Summary of Audit Findings

Error Description	Number of Errors
Failure to Document Tasks	3
Missing Documentation of Hours Billed	3
Missing Documentation of Tuberculosis Test or Follow-Up	3
Billed More Units than Documented	1
Failure to Complete Annual In-Home Visit	1
Missing Plan of Care	1
PCA Worker Not Present at Nursing Supervision Visit	1

Audit Findings Detail

OMIG's review of Medicaid claims paid to the Provider from January 1, 2017 through December 31, 2019, identified 10 claims with at least one error, for a total sample overpayment of $1,493.70 (Attachment C).

1. Failure to Document Tasks

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years ...all records necessary to disclose the nature and extent of services furnished...." *18 NYCRR Section 504.3(a)*

"(8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished.....that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years...." *18 NYCRR Section 540.7(a)(8)*

"Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program...." *18 NYCRR Section 517.3(b)(1)*

"No payment to the provider shall be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Such documentation must be maintained by the provider pursuant to section 540.7(a)(8)..." *18 NYCRR Section 505.14(h)(1)*

"... the delivery of each service is documented in the clinical record;" *10 NYCRR Section 766.2(a)(2)*

In 3 instances pertaining to 3 patients, personal care tasks were not documented. This finding applies to Sample #s 61, 71 and 74.

2. Missing Documentation of Hours Billed

"By enrolling the provider agrees: (a) to prepare and to maintain contemporaneous records demonstrating its right to receive payment under the medical assistance program and to keep for a period of six years... all records necessary to disclose the nature and extent of services furnished..." *18 NYCRR Section 504.3(a)*

"(8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished.....that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years...." *18 NYCRR Section 540.7(a)(8)*

"No payment to the provider shall be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Such documentation must be maintained by the provider pursuant to section 540.7(a)(8). . . ."
18 NYCRR Section 505.14(h)(1)

"...the delivery of each service is documented in the clinical record;..."
10 NYCRR Section 766.2(a)(2)

In 3 instances pertaining to 3 patients, the patient record did not document the personal care services billed. This finding applies to Sample #s 61, 71 and 74.

3. **Missing Documentation of Tuberculosis Test or Follow-Up**

"(d) that a record of the following tests, examinations or other required documentation is maintained for all personnel who have direct patient contact:...(4) either tuberculin skin test or Food and Drug Administration (FDA) approved blood assay for the detection of latent tuberculosis infection, prior to assuming patient care duties and no less than every year thereafter for negative findings. Positive findings shall require appropriate clinical follow up but no repeat tuberculin skin test or blood assay..." *10 NYCRR Section 766.11(d)(4)*

In 3 instances pertaining to 2 patients, a personal care aide was allowed to care for patients prior to completion of a tuberculosis test or follow up. This finding applies to Sample #s 8, 48 and 75.

4. **Billed More Units than Documented**

"(8) a dated certification by the provider that the care, services and supplies itemized have in fact been furnished.....that such records as are necessary to disclose fully the extent of care, services and supplies provided to individuals under the New York State Medicaid program will be kept for a period of not less than six years...." *18 NYCRR Section 540.7(a)(8)*

"Fee-for-service providers. (1) All providers, who are not paid at rates or fees approved by the State Director of the Division of the Budget based upon their allowable costs of operation but who are paid in accordance with the rates, fees and schedules established by the department, must prepare and maintain contemporaneous records demonstrating their right to receive payment under the medical assistance program...."
18 NYCRR Section 517.3(b)(1)

"...the delivery of each service is documented in the clinical record;..."
10 NYCRR Section 766.2(a)(2)

"No payment to the provider shall be made for authorized service unless such claim is supported by the documentation of the time spent in provision of service for each individual patient. Such documentation must be maintained by the provider pursuant to section 540.7(a)(8). . . ."
18 NYCRR Section 505.14(h)(1)

"No payment to the Provider will be made for authorized services unless each claim can be supported by documentation of the time spent per day in provision of services for each individual patient."

NYS Medicaid Program Personal Care Services Program Manual Policy Guidelines, Version 2005-1, Section III

In 1 instance, the number of units billed exceeded the number of units provided as documented in the patient record. This finding applies to Sample # 45.

5. **Failure to Complete Annual In-Home Visit**

"... an annual assessment of the performance and effectiveness of all personnel is conducted including at least one in-home visit to observe performance,...."

10 NYCRR Section 766.11(k)

In 1 instance, services were billed for a personal care aide who did not have an annual in-home visit. This finding applies to Sample # 87.

6. **Missing Plan of Care**

"The agency shall maintain a confidential record for each patient admitted to care to include:...(4) an individualized plan of care;..." *10 NYCRR Section 766.6(a)(4)*

"The governing authority or operator shall ensure that... (b) a plan of care is established for each patient based on a professional assessment of the patient's needs and includes pertinent diagnosis, prognosis, a need for palliative care, mental status, frequency of each service to be provided, medications, treatments, diet regimens, functional limitations and rehabilitation potential; . . . ." *10 NYCRR Section 766.3(b)*

"(d) the plan of care is reviewed and revised as frequently as necessary to reflect the changing care needs of the patient, but no less frequently than every six months;"

10 NYCRR Section 766.3(d)

In 1 instance, the medical record did not contain a plan of care or the required plan of care revision. This finding applies to Sample # 49.

7. **PCA Worker Not Present at Nursing Supervision Visit**

"Nursing supervision must assure that . . . the person providing such services is competently and safely performing the functions and tasks specified in the patient's plan of care."

18 NYCRR Section 505.14(f)(3)

"The nurse supervisor must perform the following functions during the supervisory visit and document his or her performance of these functions in the report he or she prepares pursuant to subparagraph (vii) of this paragraph:...(ii) evaluate the skills and performance of the person

providing personal care services, including the person's ability to work effectively with the patient and the patient's family; (iii) arrange for or provide on-the-job training. . . ."

18 NYCRR Section 505.14(f)(3)(iv)(b)(2)(ii)(iii)

"The supervisory visit must be made to the patient's home when the person providing personal care services is present. . . "

18 NYCRR Section 505.14(f)(3)(iv)(b)(1)

"Nursing supervision must include: . . . evaluation of the ability of the person providing the services and arranging for or providing necessary instructions to meet the medically related needs of the patient in keeping with the goals established by the patient's plan of care."

NYS Medicaid Program Personal Care Services Program Manual Policy Guidelines, Version 2005-1, Section II

In 1 instance, the PCA worker was not present for the nursing supervision visit. This finding applies to Sample # 43.

Repayment Options

In accordance with 18 NYCRR Part 518, which regulates the collection of overpayments, your repayment options are described below.

Option #1: Make a full payment by check, money order, or OMIG's Online Payment Portal within 20 days of the date of the Final Audit Report.

- The check should be made payable to the New York State Department of Health, should include the audit number on the memo line, and be mailed with the attached remittance advice to:

New York State Office of the Medicaid Inspector General
Bureau of Collections Management
800 North Pearl Street
Albany, New York 12204
Phone #: (518) 474-5878
Fax #: (518) 408-0593
Email: collections@omig.ny.gov

- If you elect to pay electronically through OMIG's Online Payment Portal, please visit https://omig.ny.gov/online-payment-portal or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.

Option #2: Enter into a repayment agreement with OMIG. If your repayment terms exceed 90 days from the date of the Final Audit Report, recoveries of amounts due are subject to interest charges at the prime rate plus 2%. OMIG's acceptance of a repayment agreement is based on your repaying the Medicaid overpayment as agreed. OMIG will adjust the rate of recovery, or require payment in full, if your unpaid balance is not being repaid as agreed. If you wish to enter into a repayment agreement, please contact the Bureau of Collections Management within 20 days, by telephone or email, as provided above.

Should you fail to select a payment option above within 20 days of the date of this Report, OMIG will initiate recoupment by withholding all or a part of your payments otherwise payable, in accordance with 18 NYCRR 518.6. Additionally, OMIG reserves the right to use any remedy allowed by law to collect the amount due. Pursuant to the State Finance Law Section 18(5), a collection fee equal to twenty two percent (22%) of the amount due, including interest, may be added to the amount owed.

Hearing Rights

If you choose not to settle this audit through repayment of the adjusted lower confidence limit, you have the right to challenge these findings by requesting an administrative hearing where OMIG would seek and defend the adjusted point estimate of $214,830. As allowed by state regulations, you must make your request for a hearing, in writing, within sixty (60) days of the date of this report to:

General Counsel
Office of Counsel
New York State Office of the Medicaid Inspector General
800 North Pearl Street
Albany, NY 12204

Questions regarding the request for a hearing should be directed to Office of Counsel, at (518) 408-5845.

In accordance with 18 NYCRR Section 519.18(a), "The issues and documentation considered at the hearing are limited to issues directly relating to the final determination. An appellant may not raise issues regarding the methodology used to determine any rate of payment or fee, nor raise any new matter not considered by the department upon submission of objections to a draft audit or notice of proposed agency action."

If a hearing is held, you may have a person represent you or you may represent yourself. If you choose to be represented by someone other than an attorney, you must supply along with your hearing request a signed authorization permitting that person to represent you at the hearing; you may call witnesses and present documentary evidence on your behalf.

For a full listing of hearing rights please see 18 NYCRR Part 519.

Contact Information

Shannon Kavanaugh-Gonzalez, Audit Supervisor
Shannon.Kavanaugh-Gonzalez@omig.ny.gov
(716) 847-3120

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(716) 847-3968

Office Address:

New York State
Office of the Medicaid Inspector General
Division of Medicaid Audit
295 Main Street, Suite 753
Buffalo, New York 14203

Mission

The mission of the Office of the Medicaid Inspector General is to enhance the integrity of the New York State Medicaid program by preventing and detecting fraudulent, abusive, and wasteful practices within the Medicaid program and recovering improperly expended Medicaid funds while promoting high quality patient care.

Vision

To be the national leader in promoting and protecting the integrity of the Medicaid program.

NEW YORK STATE | Office of the Medicaid Inspector General

REMITTANCE ADVICE

Ms. Jayne Rizzo, Operations Manager
South Shore Home Health Services
1225 Montauk Highway #2
Oakdale, NY 11769-1434

Provider ID #: 01085496

Audit #: 21-5901

Amount Due: $30,615

Audit Type

- ☐ **Managed Care**
- ☒ **Fee-for-Service**
- ☐ **Rate**

Checklist

1. To ensure proper credit, please enclose this form with your check.
2. Make checks payable to: New York State Department of Health.
3. Record the audit number on your check.
4. Mail the check to:

New York State Office of the Medicaid Inspector General
Bureau of Collections Management
800 North Pearl Street
Albany, New York 12204
Phone #: (518) 474-5878
Fax #: (518) 408-0593
Email: collections@omig.ny.gov

If you elect to pay electronically through OMIG's Online Payment Portal, please visit https://omig.ny.gov/online-payment-portal or contact OMIG's Bureau of Collections Management by telephone or email, at the above number or address.

Attachment A

Sample Design

The sample design used for Audit # 21-5901 was as follows:

- Universe - Medicaid claims for Personal Care services paid during the period January 1, 2017 through December 31, 2019.
- Universe Size – The universe size is 28,710 claims.
- Sampling Frame - The sampling frame for this objective is the Medicaid electronic database of Provider claims for Personal Care services paid during the period January 1, 2017 through December 31, 2019.
- Sample Unit - The sample unit is a Medicaid claim paid during the period January 1, 2017 through December 31, 2019.
- Sample Design – Simple sampling was used for sample selection.
- Sample Size – The sample size is 100 claims.

Attachment B

Sample Results and Estimates

Audit Statistics

Universe Size		28,710
Sample Size		100
Sample Value	$	16,377.65
Sample Overpayments	$	1,493.70
Confidence Level		90%

Extrapolation of Sample Findings

Sample Overpayments	$	1,493.70
Less Overpayments Not Extrapolated*		(748.03)
Sample Overpayments for Extrapolation Purposes	$	745.67
Sample Size		100
Mean Dollars in Error for Extrapolation Purposes	$	7.4567
Universe Size		28,710
Point Estimate of Total Dollars	$	214,082
Add Overpayments Not Extrapolated*		748
Adjusted Point Estimate of Total Dollars	$	214,830
Lower Confidence Limit	$	29,867
Add Overpayments Not Extrapolated*		748
Adjusted Lower Confidence Limit	$	30,615

* The actual dollar disallowance for the following findings was subtracted from the total sample overpayment and added to the Point Estimate and Lower Confidence Limit:

- **Finding #1 – Failure to Document Tasks**
- **Finding #3 – Missing Documentation of Tuberculosis Test or Follow-Up**
- **Finding #5 – Failure to Complete Annual In-Home Visit**

The dollar disallowance associated with these findings was not used in the extrapolation. However, this does not apply if an extrapolated finding was also identified for a sampled claim.

OFFICE OF THE MEDICAID INSPECTOR GENERAL
SOUTH SHORE HOME HEALTH SERVICES
REVIEW OF PERSONAL CARE SERVICES
PROJECT NUMBER: 21-5901
REVIEW PERIOD: 1/1/2017 - 12/31/2019

Sample Number	Rate Code	Date of Service	Units of Service	Units Disallowed	Amount Paid	Amount Derived	Overpayment Extrapolated	Overpayment Not-Extrapolated	DETAILED AUDIT FINDINGS	1. Missing Documentation of Tuberculosis Test or Follow-Up	2. Failure to Document Tasks	3. Missing Documentation of Hours Billed	4. PCA Worker Not Present at Nursing Supervision Visit	5. Billed More Units than Documented	6. Missing Plan of Care	7. Failure to Complete Annual In-Home Visit
1	2595	05/29/19	96	-	$ 565.44	$ 565.44	$ -	$ -								
2	2595	11/20/18	24	-	121.20	121.20	-	-								
3	2595	10/07/19	16	-	94.24	94.24	-	-								
4	2595	01/02/17	20	-	100.20	100.20	-	-								
5	2595	03/03/18	28	-	141.40	141.40	-	-								
6	2595	03/15/17	16	-	80.16	80.16	-	-								
7	2595	12/23/16	12	-	57.36	57.36	-	-								
8	2595	05/31/19	8	8	47.12	-	-	47.12		X						
9	2595	05/20/18	96	-	484.80	484.80	-	-								
10	2595	01/18/18	8	-	40.40	40.40	-	-								
11	2595	08/18/18	28	-	141.40	141.40	-	-								
12	2595	03/23/19	36	-	212.04	212.04	-	-								
13	2622	08/21/18	12	-	240.84	240.84	-	-								
14	2595	02/14/17	28	-	140.28	140.28	-	-								
15	2595	11/23/18	12	-	60.60	60.60	-	-								
16	2595	02/13/18	20	-	101.00	101.00	-	-								
17	2595	07/03/18	20	-	101.00	101.00	-	-								
18	2595	09/13/18	20	-	101.00	101.00	-	-								
19	2595	04/19/19	48	-	282.72	282.72	-	-								
20	2595	12/15/17	96	-	480.96	480.96	-	-								
21	2595	10/02/19	16	-	94.24	94.24	-	-								
22	2595	01/31/17	20	-	100.20	100.20	-	-								
23	2595	09/05/17	54	-	270.54	270.54	-	-								
24	2595	11/22/17	32	-	160.32	160.32	-	-								
25	2622	05/30/17	12	-	259.56	259.56	-	-								

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SOUTH SHORE HOME HEALTH SERVICES
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Sample Number	Rate Code	Date of Service	Units of Service	Units Disallowed	Amount Paid	Amount Derived	Overpayment Extrapolated	Overpayment Not-Extrapolated		DETAILED AUDIT FINDINGS 1. Missing Documentation of Tuberculosis Test or Follow-Up	2. Failure to Document Tasks	3. Missing Documentation of Hours Billed	4. PCA Worker Not Present at Nursing Supervision Visit	5. Billed More Units than Documented	6. Missing Plan of Care	7. Failure to Complete Annual In-Home Visit
26	2595	05/12/17	8	-	40.08	40.08	-	-								
27	2595	12/13/17	33	-	165.33	165.33	-	-								
28	2595	07/01/17	32	-	160.32	160.32	-	-								
29	2595	03/19/18	20	-	101.00	101.00	-	-								
30	2595	04/30/18	96	-	484.80	484.80	-	-								
31	2595	12/12/16	20	-	95.60	95.60	-	-								
32	2595	02/01/19	16	-	94.24	94.24	-	-								
33	2593	02/15/19	16	-	92.64	92.64	-	-								
34	2595	05/20/17	32	-	160.32	160.32	-	-								
35	2595	08/05/19	24	-	141.36	141.36	-	-								
36	2595	04/14/17	16	-	80.16	80.16	-	-								
37	2595	06/01/19	24	-	141.36	141.36	-	-								
38	2632	11/15/17	1	-	246.94	246.94	-	-								
39	2595	12/15/18	33	-	166.65	166.65	-	-								
40	2622	06/11/19	12	-	253.44	253.44	-	-								
41	2595	07/06/19	40	-	258.00	258.00	-	-								
42	2632	05/04/18	1	-	248.45	248.45	-	-								
43	2632	03/16/18	1	1	247.13	-	247.13	-					X			
44	2595	04/26/17	24	-	120.24	120.24	-	-								
45	2595	08/24/19	96	6	565.44	530.10	35.34	-						X		
46	2595	10/11/18	12	-	60.60	60.60	-	-								
47	2601	08/19/19	4	-	113.12	113.12	-	-								
48	2595	02/20/19	8	8	47.12	-	-	47.12		X						
49	2595	01/08/19	48	48	282.72	-	282.72	-							X	
50	2632	04/18/17	1	-	246.94	246.94	-	-								

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SOUTH SHORE HOME HEALTH SERVICES
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PROJECT NUMBER: 21-5901
REVIEW PERIOD: 1/1/2017 - 12/31/2019

Sample Number	Rate Code	Date of Service	Units of Service	Units Disallowed	Amount Paid	Amount Derived	Overpayment Extrapolated	Overpayment Not-Extrapolated		DETAILED AUDIT FINDINGS 1. Missing Documentation of Tuberculosis Test or Follow-Up	2. Failure to Document Tasks	3. Missing Documentation of Hours Billed	4. PCA Worker Not Present at Nursing Supervision Visit	5. Billed More Units than Documented	6. Missing Plan of Care	7. Failure to Complete Annual In-Home Visit
51	2595	02/13/19	12	-	70.68	70.68	-	-								
52	2595	03/01/18	32	-	161.60	161.60	-	-								
53	2595	10/08/19	24	-	141.36	141.36	-	-								
54	2508	12/28/17	12	-	64.92	64.92	-	-								
55	2595	11/22/17	24	-	120.24	120.24	-	-								
56	2595	05/26/18	32	-	161.60	161.60	-	-								
57	2622	07/26/19	12	-	253.44	253.44	-	-								
58	2593	09/27/19	12	-	69.48	69.48	-	-								
59	2595	04/22/19	32	-	188.48	188.48	-	-								
60	2595	07/10/19	24	-	141.36	141.36	-	-								
61	2622	02/28/18	4	4	80.28	-	80.28	-			X	X				
62	2595	11/15/17	12	-	60.12	60.12	-	-								
63	2595	09/27/17	20	-	100.20	100.20	-	-								
64	2595	06/14/17	24	-	120.24	120.24	-	-								
65	2595	10/13/18	28	-	141.40	141.40	-	-								
66	2593	02/28/18	16	-	79.04	79.04	-	-								
67	2595	01/17/18	16	-	80.80	80.80	-	-								
68	2595	04/30/19	20	-	117.80	117.80	-	-								
69	2595	01/10/17	8	-	40.08	40.08	-	-								
70	2595	03/15/17	16	-	80.16	80.16	-	-								
71	2595	05/25/17	8	8	40.08	-	40.08	-			X	X				
72	2593	07/18/18	16	-	79.04	79.04	-	-								
73	2595	10/10/18	24	-	121.20	121.20	-	-								
74	2595	04/27/17	12	12	60.12	-	60.12	-			X	X				
75	2595	11/06/19	35	35	206.15	-	-	206.15		X						

OFFICE OF THE MEDICAID INSPECTOR GENERAL
SOUTH SHORE HOME HEALTH SERVICES
REVIEW OF PERSONAL CARE SERVICES
PROJECT NUMBER: 21-5901
REVIEW PERIOD: 1/1/2017 - 12/31/2019

Sample Number	Rate Code	Date of Service	Units of Service	Units Disallowed	Amount Paid	Amount Derived	Overpayment Extrapolated	Overpayment Not-Extrapolated		DETAILED AUDIT FINDINGS 1. Missing Documentation of Tuberculosis Test or Follow-Up	2. Failure to Document Tasks	3. Missing Documentation of Hours Billed	4. PCA Worker Not Present at Nursing Supervision Visit	5. Billed More Units than Documented	6. Missing Plan of Care	7. Failure to Complete Annual In-Home Visit
76	2595	02/26/18	33	-	166.65	166.65	-	-								
77	2595	08/04/17	12	-	60.12	60.12	-	-								
78	2595	07/03/19	32	-	188.48	188.48	-	-								
79	2595	07/30/18	28	-	141.40	141.40	-	-								
80	2595	03/18/19	20	-	117.80	117.80	-	-								
81	2595	03/06/18	24	-	121.20	121.20	-	-								
82	2595	09/23/18	20	-	101.00	101.00	-	-								
83	2595	11/27/19	24	-	141.36	141.36	-	-								
84	2622	04/02/18	12	-	242.16	242.16	-	-								
85	2595	11/25/18	32	-	161.60	161.60	-	-								
86	2595	09/13/18	48	-	242.40	242.40	-	-								
87	2595	09/21/19	76	76	447.64	-	-	447.64								X
88	2595	04/06/18	12	-	60.60	60.60	-	-								
89	2595	12/19/18	94	-	474.70	474.70	-	-								
90	2595	09/04/18	20	-	101.00	101.00	-	-								
91	2595	02/22/17	96	-	480.96	480.96	-	-								
92	2595	11/14/17	16	-	80.16	80.16	-	-								
93	2595	09/18/18	20	-	101.00	101.00	-	-								
94	2595	07/28/17	12	-	60.12	60.12	-	-								
95	2595	01/08/19	69	-	406.41	406.41	-	-								
96	2595	08/01/17	12	-	60.12	60.12	-	-								
97	2623	02/19/17	2	-	21.64	21.64	-	-								
98	2632	12/16/16	1	-	235.40	235.40	-	-								
99	2622	01/07/17	8	-	173.04	173.04	-	-								
100	2595	09/19/19	20	-	117.80	117.80	-	-								
Totals					**$ 16,377.65**	**$ 14,883.95**	**$ 745.67**	**$ 748.03**		**3**	**3**	**3**	**1**	**1**	**1**	**1**